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APPENDIX D

SERVICE AUTHORIZATION INFORMATION

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INTRODUCTION

Service Authorization (Srv Auth) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus, FAMIS or FAMIS MOMS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require Srv Auth and some may begin prior to requesting authorization.

PURPOSE OF SERVICE AUTHORIZATION

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid/FAMIS eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity. Medallion 3 MCO-enrolled members are subject to service authorization requirements of the individual's MCO.

GENERAL INFORMATION REGARDING SERVICE AUTHORIZATION

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for Srv Auth requests.

The Srv Auth entity will approve, pend, reject, or deny all completed Srv Auth requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request.

CHANGES IN MEDICAID ASSIGNMENT

Because the individual may transition between fee-for-service and the Medicaid managed care (MCO) program, the Srv Auth entity will honor the Medicaid MCO service authorization if the client has been retroactively disenrolled from the MCO. Similarly, the MCO will honor the Srv Auth Contractor's authorization based upon proof of authorization from the provider, DMAS, or the Srv Auth Contractor that services were authorized while the member was eligible under fee-for-service (not MCO enrolled) for dates where the member has subsequently become enrolled with a DMAS contracted MCO Srv Auth decisions by the DMAS Srv Auth Contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of

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service requested. The Srv Auth Contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify member eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled members, the provider must follow the MCO's Srv Auth policy and billing guidelines.

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) PROGRAM

Members Transitioning into CCC Plus

For members that transition into the CCC Plus Program, the CCC Plus Health Plan will honor the Srv Auth contractor's authorization for a period of not less than 30 days or until the Srv Auth ends whichever is sooner, for providers that are in-and out-of-network.

When a member enrolls in CCC Plus, the provider should contact the CCC Plus Health Plan to obtain an authorization and information regarding billing for services if they have not been contacted the CCC Plus Health Plan.

Members Transitioning from CCC Plus and Back to Medicaid Fee-For Service (FFS)

Should a member transition from CCC Plus to Medicaid FFS, the provider must submit a request to the Srv Auth Contractor and needs to advise the Srv Auth Contractor that the request is for a CCC Plus transfer within 60 calendar days. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. The Srv Auth Contractor will honor the CCC Plus approval up to the last approved date but no more than 60 calendar days from the date of CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the SA Contractor will apply medical necessity/service criteria.

Should the request be submitted to the Srv Auth Contractor after the continuity of care period:

- A. The dates of service within the continuity of care period will be honored for the 60-day timeframe;
- B. The dates of service beyond the continuity of care period, timeliness will be waived and reviewed for medical necessity, all applicable criteria will be applied on the first day after the end of the continuity of care period
- C. For CCC Plus Waiver Services, cap hours will be approved the day after the end of the continuity of care period up to the date of request. The continuation of service units will be dependent upon service criteria being met and will either be authorized or reduced accordingly as of the date of the request.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the *beginning* of the month. This will provide information for members who may be in transition from CCC Plus at the very end of the previous month.

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Should there be a scenario where DMAS has auto closed (ARC 1892) the SA Contractor's service authorization but the member's CCC Plus eligibility has been retro-voided, continuity of care days will not be approved by the CCC Plus health plan and will not be on the transition reports since the member never went into CCC Plus. The SA Contractor will re-open the original service authorization for the same provider upon provider notification.

CCC Plus Exceptions:

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Srv Auth Contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)
- If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Srv Auth Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, click on the link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

THE GOVERNOR'S ACCESS PLAN (GAP) (FEE-FOR-SERVICE MEMBERS)

Some GAP members will remain in fee-for-service and will receive their medical service authorization through DMAS' Service Authorization Contractor, Keystone Peer Review Organization (KEPRO). The services received through fee-for-service will not change from the current GAP services. These members will **not** receive the new Medicaid Expansion benefits and will continue to use their GAP identification card through March 31, 2019, when the GAP program ends. KEPRO will accept requests for GAP (medical) services through March 31, 2019 at 11:59 pm. Requests received on and after April 1, 2019 will be rejected.

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The Governor's Access Plan (GAP) for medical and behavioral health services is restricted to Virginia adults (ages 21 through 64) who have a serious mental illness. The GAP benefit plan includes limited medical coverage where some of these services require service authorization through DMAS' Service Authorization Contractor, Keystone Peer Review Organization (KEPRO). Service authorization is required for the following Traditional medical services:

- Non-emergent, outpatient Magnetic Resonance Imaging (MRI scan) *
- Non-emergent, outpatient Computerized Axial Tomography (CAT scan) *
- Durable Medical Equipment: limited to overage Diabetic Supplies only
- Surgical Procedures (specific procedure codes only)
- Medical Device Services/Maintenance (specific procedure/HCPCS codes only)

*Only services performed in outpatient facility settings. All others limited to physician's office only. Physician office includes Health Department Clinics, Rural Health Clinics (RHC), and Federally Qualified Health Clinics (FQHC).

Should a service require service authorization under the GAP benefit plan, providers must submit a request according to the specific service type standards to meet the timeliness requirements (when appropriate) as well as medical documentation to meet the service specific criteria.

The specific DME diabetic supply codes covered by GAP are included in the Durable Medical Equipment and Supplies Manual, Appendix B, "Diabetic Products" section. Providers should review Chapter IV and Appendix B to determine medical necessity criteria, the allowable amount for each code (no service authorization required) and any overage amount that requires service authorization.

Refer to KEPRO's website <http://dmas.kepro.com/> for procedure codes and HCPCS codes that are included in the GAP benefit and require service authorization by KEPRO. All codes are subject to change so providers must refer to KEPRO's website for any updates. Information may be found on the DMAS website, Service Authorization section, at the following link: http://www.dmas.virginia.gov/Content_pgs/pa-home.aspx.

For general GAP information, refer to the GAP Supplement C found on the DMAS web portal, Provider Services, Provider Manuals section. The GAP link also provides useful information: http://www.dmas.virginia.gov/Content_pgs/GAP.aspx.

COMMUNICATION

Provider manuals are located on the DMAS and KEPRO websites. The contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to <http://dmas.kepro.com> and clicking on the *Forms* tab for fax forms to request services. A service specific checklist may be found by clicking on "Service Authorization Checklists" on KEPRO's website. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Outpatient* tab.

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The Srv Auth entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the Srv Auth process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

Service Authorization reviews will be performed by DMAS' service authorization contractor, Keystone Peer Review Organization, (KEPRO). All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests submitted to KEPRO.

There are no automatic renewals of service authorizations. Providers must submit a service authorization request if a member requires continued services or the current authorization will end without renewal.

KEPRO accepts service authorization (srv auth) requests through direct data entry (DDE), fax, phone and US mail. The preferred method is by DDE through KEPRO's provider portal, Atrezzo Connect. To access Atrezzo Connect on KEPRO's website, go to <http://dmas.kepro.com>. For direct data entry requests, providers must use Atrezzo Connect Provider Portal.

PROVIDER REGISTRATION IS REQUIRED TO USE ATREZZO CONNECT

The registration process for providers happens immediately on-line. From <http://dmas.kepro.com>, providers not already registered with Atrezzo Connect may click on the Atrezzo icon on the website to register. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount.

The Atrezzo Connect User Guide is available at <http://dmas.kepro.com>: Click on the *Training* tab, then the *General* tab.

Providers with questions about KEPRO's Atrezzo Connect Provider Portal may contact KEPRO by email at atrezzoissues@kepro.com. For service authorization questions, providers may contact KEPRO at providerissues@kepro.com. KEPRO may also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

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KEPRO's website has information related to the service authorization processes for all Medicaid programs they review. Fax forms, service authorization checklists, trainings, methods of submission and much more are on KEPRO's website. Providers may access this information by going to <http://dmas.kepro.com>.

Processing Requests at KEPRO

KEPRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached KEPRO notifies the member and the provider in writing of the status of the request through the MMIS letter generation process.

If there is insufficient information to make a final determination, KEPRO will pend the request back to the provider and request additional information. If the information is not received within the time frame requested by KEPRO, the request will automatically be sent to a physician for a final determination with all information that has been submitted. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instructions on how to file an appeal is included in the MMIS generated letter.

If services cannot be approved for members under the age of 21 using the current criteria, KEPRO will then review the request by applying EPSDT criteria.

The MMIS generates letters to providers, case managers, and members depending on the final determination. DMAS will not reimburse providers for dates of service prior to the date(s)

identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individuals file, and are subject to review during post payment review. Please see additional requirements in Chapter VI of this manual.

The following documentation is required in order to determine if the individual meets criteria:

(1) Certificate of Medical Necessity (CMN), unless items meet exception criteria stated in Chapter IV; (2) Supporting documentation verifying item specific coverage criteria stated in Chapter IV; and (3) Documentation of usual and customary charges or cost as necessary for each HCPCS code used from Appendix B.

All items and supplies must meet the coverage criteria in Chapter IV of this manual and the Virginia Administrative Code. In addition, DMAS requires specific categories of items meet the InterQual criteria. These categories are: adaptive strollers, nebulizers (including compressors), augmentative communication devices (AAC and speech generating devices), continuous passive motion devices, cranial molding orthosis, oxygen, hospital beds, insulin pumps, lower extremity orthosis (knee braces and immobilizers), lymphedema compression devices, manual wheelchairs, negative pressure wound therapy devices, CPAP and BiPAP devices, power wheelchairs and scooters, seat lift mechanisms (not lift chairs), secretion clearance devices, standing frames, support surfaces, TENS, wheelchair cushions and seating systems.

The above list is subject to change with InterQual updates and DMAS discretion.

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- The medical justification provided to the Service Authorization Contractor must meet the DME InterQual Criteria upon review. These criteria may be obtained through:

McKesson Health Solutions LLC
275 Grove Street
Suite 1-110
Newton, MA 02466-2273
Telephone: 800-274-8374
Fax: 617-273-3777
Website: www.mckesson.com or www.InterQual.com

Subsequent Recertification Review

Prior to the end of the last authorized date, the provider should submit the required documents for continued service authorization. The documentation will be reviewed to determine if it meets DMAS criteria and documentation requirements found in Chapters IV and VI of this manual, including the practitioner's signature and date on the certificate of medical necessity. The DMAS service authorization contractor will make a decision to approve, pend, deny, or reject the request. If approved, the service authorization contractor will authorize a specific number of units and dates of service based on the documentation submitted.

FACE-TO-FACE ENCOUNTER FOR FEE-FOR-SERVICE DME

This only applies to FFS members and not those enrolled in one of DMAS' managed care organizations (MCO), unless otherwise required in the provider's contract with the managed care plan.

Beginning July 1, 2017, no payment shall be made for new DME (as defined in [12VAC30-50-165](#)) unless a face-to-face encounter has been performed by an approved practitioner (outlined below) no more than six (6) months prior to the begin service date. The face-to-face encounter shall be related to the primary reason the individual enrolled in Medicaid requires DME.

The face-to-face encounter for DME must be conducted by one of the following four (4) practitioners:

- A physician licensed to practice medicine;
- A licensed nurse practitioner or licensed clinical nurse specialist within the scope of their practice under state law, working in collaboration and with a practice agreement with the physician who orders the Medicaid individual's services;
- A licensed physician assistant within the scope of their practice under state law and working under the supervision of the physician who orders the individual's services; or
- For individuals requiring DME immediately after an acute or post-acute stay, the attending acute or post-acute physician.

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The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering physician.

Providers must use the revised CMN form to document the new requirements. Completion of all elements related to the face-to-face requirements on the CMN will satisfy the face-to-face encounter documentation requirements.

Please refer to Chapters IV and VI of the DME Provider Manual for DME items that require service authorization. When a face-to-face encounter is required, providers must, during the service authorization process, "attest" that the face-to-face encounter requirement has been met. For those items that do not require a service authorization, the CMN with the face-to-face encounter documentation should be maintained in the individual's medical record.

NOTE: A face-to-face encounter is only required for Medicaid DME items that also require a face-to-face encounter under the Medicare program. If a face-to-face encounter is not required for a specific DME item under the Medicare program, then it is not required for the Medicaid program. For a list of fee-for-service DME codes that require a face-to-face, please refer to Chapters IV and VI of the DME Provider Manual.

Breast Pumps for Pregnant and Postpartum Women

Coverage of breast pumps, for pregnant and postpartum women enrolled in the fee-for-service Medicaid/FAMIS/FAMIS MOMS benefits is effective January 1, 2016. (Refer to DMAS Memo dated December 2015.) Please note that as of July 1, 2022, Medicaid and FAMIS MOMS coverage is effective for the duration of pregnancy and for a 12-month postpartum period beginning on the last day of the pregnancy and including any remaining days of the calendar month in which the 12-month period ends. See also Chapter IV and Appendix B of this manual. The DMAS contracted MCOs currently cover breast pumps for their enrolled members.

Breast Pumps

DMAS will cover a manual or standard electric breast pump as medically necessary for the initiation or continuation of breastfeeding (up to the child's first birthday). These breast pump codes are available as of January 1, 2016:

- E0602 Manual breast pump, purchase – does **not** require service authorization;
- E0603 Single user electric breast pump, purchase – requires service authorization;
- E0604 Multi-user (Hospital grade) electric pump, rental – requires service authorization;
- E1399 Additional collection kit for use with the single and multi-user electric breast pumps - requires service authorization.

E0603 - Single user electric breast pumps - purchase

A personal use electric breast pump is designed for mothers who are breastfeeding without problems. A personal use electric breast pump is defined as a double electric (AC and/or DC) pump, intended for a single user and is capable of being used multiple times per day. Payment includes supplies necessary for operation of the pump (pump, adapter/charger, breast shields,

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bottles, lids, tubing, locking ring, connectors, valves, filters and membranes). DMAS medical necessity criteria as follows:

- Mother must express the desire to breastfeed;
- The pump must be FDA registered;
- The pump has a minimum one-year manufacturer's warranty; and
- The pump must have a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma.

Limits: One purchase every three (3) years. Request must be medically justified. Request duration is 30 days (for pick up/delivery). DMAS allows for one additional purchase every three years with medical justification.

E0604 – Multi-user (Hospital grade) electric pumps - rental

Multi-user/Hospital grade electric pumps are designed to initiate and maintain a milk supply when a baby is not feeding well. The pump must be FDA registered and have a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma.

DMAS coverage of hospital grade rental pumps must meet the medical necessity criteria below:

- When the infant is premature at 24-34 weeks of gestation, and the mother is pumping breast milk, awaiting the baby's ability to nurse directly from the breast;
- When the infant is premature at 35-37 weeks of gestation and continues to experience difficulty coordinating suck and swallow, and the mother is pumping breast milk, awaiting the baby's ability to nurse directly from the breast;
- For infants with cleft lip and/or palate or ankyloglossia who are not able to nurse directly from the breast;
- For infants with cardiac anomalies or any medical condition that makes them unable to sustain breast feeding due to poor coordination of suck and swallow or fatigue;
- For multiples (including twins), until breast-feeding at the breast is established consistently;
- When the mother has an anatomical breast problem, which may resolve with the use of breast pump, such as insufficient glandular tissue;
- For any infants for medical reasons who are temporarily unable to nurse directly from the breast, such as NICU babies, or during any hospitalization of the mother or baby which will interrupt nursing; or
- When the infant has poor weight gain related to milk production and pumping breast milk is an intervention in the provider's plan of care and infant has a documented weight loss of 7% or greater despite use of conventional breast pump.

A hospital grade breast pump is not medically necessary when one of the above criteria are not met or when it is requested solely to allow for the mother's return to work or mother's or family convenience.

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Limits: Up to 6 months initial rental period based on medical necessity. 12-month **maximum** rental period per member with medical justification. Requests for additional months after the initial 6 months must include why purchase of a single user electric pump (E0603) will not meet member's needs.

E1399 – Collection kits for use with the single and multi-user electric breast pumps

One collection kit for electric breast pumps includes necessary supplies and collection containers. The service limit is one additional kit per single or multi-user electric breast pump authorization. Providers must include medical justification when requesting an additional kit. Each breast pump includes an initial collection kit. Providers must bill their Usual and Customary Charge (UCC). Additional collection kits have a maximum reimbursement rate; 1 unit equals 1 kit. **There is no mark up for additional collection kits.**

Limits: One (1) per service limit period for single-user and multi-user electric pumps. Request must be medically justified; provider must indicate pump is owned or rental and that the additional collection kit is appropriate for member owned (or rental) pump. Request duration: 30 days (for pick up/delivery).

DME providers must submit medical justification to KEPRO when requesting these codes. Providers must have a completed CMN (DMAS 352) on file.

OUT-OF-STATE PROVIDER INFORMATION

Effective March 1, 2013, there is a change in the policy and procedure for out-of-state requests submitted by out-of-state providers. This change impacts out-of-state providers who submit Virginia Medicaid service authorization requests to Keystone Peer Review Organization (KEPRO), DMAS' service authorization contractor, and any other entity to include, but not limited to, DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) when providing service authorizations for the services listed in the DMAS memo dated February 6, 2013 and titled "*Notification of a Procedural Change for Out-of-state Providers Submitting Requests for Service Authorization Through KEPRO,*" which can be accessed at <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>.

KEPRO's service authorization process for certain services will include determining if the submitting provider is considered an out-of-state provider. Out-of-state providers are defined as those providers that are either physically outside the borders of the Commonwealth of Virginia or do not provide year end cost settlement reports to DMAS. Please refer to the above referenced DMAS memo dated February 6, 2013. Additional information is provided below.

Specific Information for Out-of-State Providers

Out-of-state providers are held to the same service authorization processing rules as in-state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-

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state services to KEPRO. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to KEPRO, as timeliness of the request will be considered in the review process. KEPRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.

If KEPRO receives the information in response to the pend for the provider's enrollment from the newly enrolled provider within the 12 business days, the request will then continue through the review process and a final determination will be made on the service request.

If the request was pended for no provider enrollment and KEPRO does not receive the information to complete the processing of the request within the 12 business days, KEPRO will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request.

Out-of-state providers may enroll with Virginia Medicaid by going to <https://www.viriniamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment>. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

Out-of-State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers. Procedures and/or services may be performed out-of-state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.

Services provided out-of-state for circumstances other than these specified reasons shall not be covered:

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is the general practice for recipients in a particular locality to use medical resources in another state.

The provider needs to determine which item 1 through 4 is satisfied at the time of the request to the Contractor. If the provider is unable to establish one of the four, the Contractor will:

- Pend the request utilizing established provider pend timeframes; and
- Have the provider research and support one of the items above and submit back to the Contractor their findings.

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“Effective September 12, 2016, KEPRO added additional questions to the Out-of-state Provider questionnaire (found on the Provider Portal):

- a. Question #2-Are the medical services needed, will the recipient’s health be endangered if required to travel to state of residence? If a provider answers “Yes”, then additional question #2.1.1 asks: “Please explain the medical reason why the member cannot travel”.
- b. Question #5- “In what state is the provider rendering the service and/or delivering the item physically located?”
- c. Question #6- “In what state will this service be performed?”
- d. Question 7- “Can this service be provided by a provider in the state of Virginia? If a provider answers “No”, then additional question #7.2.1: “Please provide justification to explain why the item/service cannot be provided in Virginia.”

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52.

SERVICE AUTHORIZATION PROCESS

The “Medicaid DME Supplies Listing”/Appendix B which is based on the Health Care Financing Administration Common Procedure Coding System (HCPCS), describes equipment and supplies and identifies those which require service authorization. Service authorization is required for items identified with a “Y” in the authorization column of the DME Listing/Appendix B, and for any item exceeding the established limits identified in the “limit” column of the DME Listing/Appendix B. **The DME Listing/Appendix B identifies the information above. It does not determine coverage of an item. Coverage criteria are in Chapter IV of the Durable Medical Equipment and Supplies Manual and the Virginia Administrative Code.**

Service authorization is requested by the enrolled DME provider and not by healthcare professionals involved with the enrollee’s care. The provider completes and/or gathers the necessary documentation to meet the Medicaid criteria as described in Chapter IV of this manual.

When extended utilization or unusual amounts of equipment and/or supplies are required, the provider must request service authorization. If the item does not require service authorization or does not exceed the established limits, the provider may provide and bill for these items up to the established limit without service authorization. If service authorization is required, service authorization must be obtained regardless of whether or not Medicaid is the primary payer, except for Medicare-crossover claims.

The purpose of service authorization is to validate that the service or item being requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not automatically guarantee payment for the service. Payment is contingent upon passing all edits

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contained within the claims payment process; the member's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided. Service authorizations are specific to a member, a provider, a service code, an established quantity, and for specific dates of service. (12 VAC 30-50-165)

Appendix B

The Appendix B is based upon the Healthcare Common Procedure Coding System (HCPCS), which describes equipment and supplies, coverage limitations, and service authorization requirements. Service authorization by Medicaid is not required when Medicare is the primary payer.

When extended utilization or unusual amounts or types of equipment or supplies are required, the provider must request service authorization from the Department of Medical Assistance Services' (DMAS) service authorization contractor. Items not identified in the Appendix B listing require service authorization and may be submitted for service authorization under the appropriate miscellaneous HCPCS code. Lack of a specific HCPCS code for the item does not determine coverage. The appropriate miscellaneous code may be used and submitted for service authorization.

Providers must maintain documentation in accordance with the coverage criteria, documentation requirements, and Certificate of Medical Necessity (CMN) requirements as defined in Chapters IV and VI of this Provider Manual, regardless of whether or not service authorization is required.

Miscellaneous HCPCS Codes

Miscellaneous codes may only be used when the item requested differs significantly in narrative description from the established HCPCS code. Miscellaneous codes will not be recognized for the sole purpose of cost variances. In order for the service authorization contractor to determine the appropriate reimbursement for miscellaneous items not in the Appendix B with a fee, all of the following information must be provided:

- A complete description of the item(s) being supplied;
- A copy of the manufacturer's/supplier's invoice or the dealer cost information to document the cost of the item(s);
- For any specially designed items, a statement from the manufacturer detailing cost; and
- Any discount received must be indicated.

The service authorization file in VAMMIS combines all like miscellaneous DME codes into one 'summary' line, which carries the status of AC (approved combined). Providers see the AC line on their service authorization notification report and in order to bill for miscellaneous DME lines, providers will need to total the authorized amounts as well as the authorized units for each

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of the miscellaneous codes and submit this total or 'summary line' amount as one-line item on the claim.

The provider should bill the total number of units and the total authorized fee once all supplies are delivered. If the provider does not deliver all units at one time the provider can follow the instructions below:

1. Submit a change request to the DMAS Srv Auth Contractor. The provider will request a change to the line item that was not delivered by either decreasing the number of units or voiding the line item for the DME/supplies that was not delivered and if necessary create a new service authorization for item not delivered;
2. Wait until all DME/supplies are delivered to submit the claim for reimbursement; or
3. If the provider has already billed for the all DME/supplies but has not delivered all units, the provider will need to adjust the claim. If it is found on post payment audit that the provider has billed all units but not delivered all units the provider may have funds retracted.

For DME items that have a national code but do not have a DMERC or rate for July 1, 2010 mark-up of 30 percent of the actual cost (less any discounts available to the DME provider), as determined by the service authorization contractor. If the provider receives a manufacturer/supplier discount and cost plus 30% mark-up equates to greater than the manufacturer's suggested retail price (MSRP), then reimbursement will be the MSRP. The provider should mark box 23 on the Outpatient Service Authorization Request Form/ DMAS 363 (7/2010) with the cost plus 30% mark up. The reimbursement will be based on the provider description of the item(s) or supplies. Providers should review instructions for the DMAS 363 form prior to completing the form. Adequate and complete descriptions, quantities, and the unit price are essential for the evaluation of the charge. Wherever possible, use the appropriate HCPCS codes.

Incontinence Supplies

Providers are required to obtain Service Authorization (SA) for incontinence supplies over the allowable limit, as described in Appendix B of this manual. When requesting service authorization, the required billing unit for incontinence supplies (diapers/pull-up/panty liners) is "each" (not case). See Chapter IV of this manual for details.

For Service Authorization Requests Submitted Through the DMAS Srv Auth Contractor On and After January 1, 2010

In order to facilitate the change from 'case' to 'each' providers should request service authorization (Srv Auth) through the DMAS Srv Auth Contractor through June 30, 2010 on a separate line of the request, identifying the number of cases needed. For requests with dates of service July 1, 2010 and forward, a separate line is needed identifying the number of each product being requested. Both lines may be submitted within the same request.

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Any requests to change existing Service Authorizations must include the Srv Auth number, and reference ‘cases’ for dates of service through June 30, 2010 and reference ‘each’ for dates of service July 1, 2010 and forward. When requesting the changes, be sure to include the existing Srv Auth number as reference.

HOW TO DETERMINE IF SERVICES NEED SERVICE AUTHORIZATION

In order to determine if services need to be service authorized, providers should go to the DMAS website: <http://dmasva.dmas.virginia.gov> and look to the right of the page and click on the section entitled Procedure Fee Files which will then bring you to this: http://www.dmas.virginia.gov/Content/pgs/pr-ffs_new.aspx. You will now see a page entitled DMAS Procedure Fee Files. The information provided there will help you determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

To determine if a service needs Service Authorization, you would then determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version. The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the following:

- 00-No PA is required
- 01-Always needs a PA
- 02-Only needs PA if service limits are exceeded
- 03-Always need PA, with per frequency.

To determine whether a service is covered by DMAS you need to access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides you special coverage and/or payment information. A Procedure Flag of “999” indicates that a service is non-covered by DMAS.

EARLY PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICE AUTHORIZATION

EPSDT is a Federal law (42 CFR § 441.50 et seq) which requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, and is composed of two parts:

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1. EPSDT promotes the early and universal assessment of children's healthcare needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. These services must be provided by Medicaid at no cost to the member.
2. EPSDT also compels state Medicaid agencies to cover other services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" [make better] a defect, physical or mental illness, or condition [health problem] identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service for adults under the state plan. For more information, visit: <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>.

EPSDT is Medicaid's comprehensive and preventive child health benefit for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible before the problem becomes complex and treatment is costlier. Examination and treatment services are provided at no cost to the member.

All Medicaid and FAMIS Plus services that are currently service authorized by the Srv Auth Contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, DMAS.KePRO.com. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX OR 1-877-652-9329.

Example of EPSDT Review Process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

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The review process as described is to be applied across all non-waiver Medicaid programs for children. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT benefit. Examples of non-covered services are inclusive of but are not limited to the following services: residential substance abuse treatment, behavioral therapy, specialized residential treatment not covered by the psychiatric services program. All service requests must be a service that is listed in (Title XIX Sec. 1905.[42 U.S.C. 1396d] (r)(5)).

NOTE: Effective November 1, 2012, EPSDT specialized services that are service authorized by Keystone Peer Review Organization (KEPRO), DMAS' service authorization contractor include:

Hearing Aids and Related Devices
Assistive Technology
Private Duty Nursing
Personal Care and Attendant Care Services

Requests for services **not service authorized by KEPRO** may be sent to:
EPSDT Service Authorization Coordinator
Fax: 804-452-5462 Phone: 804-786-6134

MEDICAID EXPANSION

On January 1, 2019, Medicaid expansion became effective. Individuals eligible for Medicaid expansion are:

- Adults ages 19-64,
- Not Medicare eligible,
- Not already eligible for a mandatory coverage group,
- Income from 0% - 138% Federal Poverty Level (FPL), and
- Individuals who are 100% - 138% FPL with insurance from the Marketplace.

The new expansion aid categories:

Aid Category	Description
AC 100	Caretaker Adult, Less than or equal to 100% of the Federal Poverty Level (FPL) and greater than LIFC
AC 101	Caretaker Adult, Greater than 100% FPL
AC 102	Childless Adult, Less than 100% FPL
AC 103	Childless Adult, Greater than 100% FPL

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AC 106	Presumptive Eligible Adults Less than or equal to 133% FPL
AC 108	Incarcerated Adults

The Medicaid Expansion Benefit Plan includes the following services:

Covered Service
Doctor, hospital and emergency room services
Prescription drugs
Laboratory and x-ray
Maternity and newborn care
Behavioral health services including addiction and recovery treatment
Rehabilitative and habilitative services including physical, occupational, and speech therapies and equipment
Family planning
Transportation to appointments
Home Health
DME and supplies
Long Term Support Services (LTSS) to include Nursing Facility, PACE and Home and Community Based Service
Preventive and wellness
Chronic disease management
Premium assistance for the purchase of employer-sponsored health insurance coverage, if cost effective
Referrals for job training, education and job placement

All of the services currently submitted and reviewed by KEPRO remain the same. There are no new expansion benefits that require service authorization by KEPRO.